Section 2

Home and Community-Based Waiver Services (HCBWS) for Technology Dependent, Medically Fragile Individuals

Table of Contents

1 GENERAL POLICY

Section 1915 (c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, Medicaid funded home and community-based waiver services to eligible individuals as an alternative to institutional care. Utah's home and community-based Medicaid waiver for technology dependent/medically fragile individuals (also referred to as the "Travis C. Waiver") was initially approved by the Centers for Medicare and Medicaid Services (CMS) effective January 1, 1995, for a three year period and has been continuously reauthorized at five year intervals since 1998. Admission to this waiver is limited to individuals who meet the targeting criteria found in Section 2-1 of this manual.

Federal approval includes authorization to "waive" Medicaid comparability requirements found at section 1902(a)(10)(B) of the Social Security Act. This allows the State to "target" Medicaid reimbursed home and community-based services to a *limited number* of technology dependent, medically fragile individuals. Additionally, the State is authorized to waive certain income and resource rules found in Section 1902(a)(10)(c)(I)(III) of the Act when determining eligibility for the waiver.

1 - 1 Purpose

Medical technology makes it possible to enhance the lives of medically fragile individuals with special needs. Historically, many families have found it necessary to place a medically fragile individual in an institutional setting in order to obtain needed services and supports. Utah's home and community-based waiver program is designed to offer these individuals and their families an option to premature or unnecessary institutionalization. Under this waiver program, individuals who would otherwise require a level of care provided in a nursing facility may instead be offered the choice to receive Medicaid reimbursed services at home and in their community. Waiver recipients are eligible to receive non-institutional and home and community-based services **in addition to** traditional medical services covered by Medicaid and other insurers.

1 - 2 Waiver Administration and Operation

A. Division of Health Care Financing: Administrative Authority and Responsibilities

The Division of Health Care Financing is the single State agency responsible to administer and supervise the administration of the Utah Medicaid program including waiver programs. State funds appropriated by the Utah legislature to the Division of Health Care Financing are used to match Federal Medicaid funds in order to cover the costs of this waiver program.

The Division of Health Care Financing retains final administrative authority for the waiver as it currently exists or is hereafter amended.

B. Division of Community and Family Health Services: Operational Authority and Responsibilities

The Division of Community and Family Health Services is the State's Maternal and Child Health, Title V designee, and has the statutory authority and responsibility to provide and/or arrange for the provision of services to children and youth with special health care needs (CYSHCN). Under an interagency agreement with the Division of Health Care Financing, the Division of Community and Family Health Services provides "waiver case management" and other essential activities necessary to ensure the effective and efficient, day to day operations of the waiver program.

1 - 3 Definitions

For purposes of the Home and Community-Based Waiver for Technology Dependent, Medically Fragile Individuals, the following definitions apply:

Applicant: A child who has applied for services under the waiver, but who has not yet been determined eligible, or not yet received approval, for services under the Home and Community-based Waiver for Technology Dependent, Medically Fragile Individuals.

Child: An individual under the age of 21.

Medicaid Eligibility Worker: A qualified employee of the Division of Health Care Financing who determines categorical and financial eligibility for Medicaid.

Plan of Care: The plan of care is written by the waiver case manager to describe services needed by the individual and authorized by the waiver case manager.

Prior Authorization: Authorization received BEFORE services are provided.

Recipient: An individual who qualifies for and receives services under the waiver.

Waiver or Waiver services: The Home and Community-Based Waiver for Technology Dependent, Medically Fragile Individuals and services covered under the waiver.

Waiver Case Manager: A qualified employee of the Division of Community and Family Health Services who performs required case management activities under the Home and Community-Based Waiver for Technology Dependent, Medically Fragile Individuals.

2 SERVICE AVAILABILITY

Home and community-based waiver services for technology dependent, medically fragile individuals are covered benefits only when provided in accordance with the four criteria listed below.

A. To individuals eligible for the waiver and residing in the State of Utah;

B. To individuals who are not inpatients of a hospital, nursing facility, or intermediate care facility for the mentally retarded.

C. Pursuant to a written plan of care;

D. Through a qualified, enrolled Medicaid provider as described in Chapter 3, SCOPE OF SERVICE.

Details concerning the eligibility process and these four criteria are explained in the remainder of this chapter.

2 - 1 Eligible Individuals

A. To be eligible for services under this waiver, the technology dependent, medically fragile individual must meet all six of the following "targeting criteria":

1. Be under the age of 21 at the time of admission;

2. Qualify for Medicaid based on his or her income and resources;

3. Have at least one care giver trained (or willing to be trained) and available to provide care in a home that is safe and able to accommodate the necessary medical equipment and personnel needed to safely care for the individual;

4. Meet admission criteria for Nursing Facility (NF) care;

5. Choose to receive home and community-based services; and

6. Require skilled nursing or rehabilitation services (or a combination of both) at least five days per week. The services ordered must be, singly or in the aggregate, so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. For purposes of this waiver, the inherent complexity of services is evidenced by the individual's dependence on one or more of the following:

   a. Daily dependence on a mechanical ventilator;

   b. Daily dependence on tracheostomy-based respiratory support;

   c. Dependence within the past six months on tracheostomy-based respiratory support;

   d. Daily dependence on continuous or intermittent positive airway pressure (C-PAP or Bi-PAP); or

   e. Dependence on intravenous administration of nutritional substances or medications through a central line, which the physician anticipates will be necessary for a period of at least six months.

B. An individual's eligibility for benefits and services under this waiver can continue as long as he or she continues to meet the targeting criteria.

2 - 2 Access to Waiver

The first point of contact for all waiver services is the Division of Community and Family Health Services waiver case manager. Prior to an applicant receiving waiver services, the case manager must:

A. Certify that the applicant meets the level of care requirements, and that there are feasible alternatives available under the waiver;

B. Ensure the applicant has been determined financially eligible for Medicaid based on waiver eligibility requirements; and

C. Offer the eligible applicant the choice of waiver services or nursing facility services.

2 - 3 Level of Care Determination (Certification)

A. The waiver case manager, through consultation with the child's medical home and other health professionals and with the assistance of the applicant and/or the applicant's legal representative, will obtain pertinent information needed to thoroughly evaluate the applicant's medical condition and technology.

B. An applicant meets the level of care criteria when documentation supports the following:

1. The applicant's condition and technology needs meet the targeting criteria defined in Chapter 2 - 1, *Eligible Individuals*;

2. There is a reasonable indication that the applicant might need the level of care provided in a Medicaid certified nursing facility in the near future (that is a month or less) unless he or she receives home or community-based waiver services; and

3. The applicant's needs can be appropriately met in the community with the currently available waiver and other state plan services.

C. Individuals who meet the waiver targeting criteria but whose needs cannot be met appropriately in the community with waiver and other available state plan services will receive written notice from the case manager specifying the reason(s) for ineligibility, and the applicant's rights to request a hearing. Hearing rights are described in Chapter 2 - 10.

D. To support the level of care determination, the following documentation must be included in the applicant's case management record:

1. Comprehensive assessment completed by the waiver case manager which documents the individual's medical history, current technologies, treatments, services and identified needs.

2. The Waiver Level of Care Evaluation Form and the Initial and Annual Level of Care/Freedom of Choice Certification Form.

3. Copies of other pertinent medical information which supports that the individual meets the waiver targeting criteria and the required nursing facility level of care.

2 - 4 Medicaid Eligibility Determination

A. Once an applicant has been certified by the case manager as meeting the waiver targeting and level of care criteria specified in Chapters 2 - 1 and 2 - 3, he or she will be referred by the waiver case manager (using completed HCF-927 form) to the Division of Health Care Financing, Bureau of Eligibility Services, for a determination of Medicaid eligibility.

B. The Medicaid eligibility worker will coordinate with the waiver case manager to obtain all necessary documentation to complete the Medicaid application. The eligibility worker will notify the waiver case manager of the Medicaid eligibility determination, again using the form 927.

2 - 5 Individual's Freedom of Choice

A. Once an applicant has been certified by the case manager to meet the level of care criteria for the waiver and the eligibility worker has determined the individual meets Medicaid categorical and financial eligibility requirements, the applicant or his or her legal representative will be:

1. Informed by the case manager of feasible and available services under the waiver;

2. Advised if there is a waiting list for admission to waiver services (Refer to Chapter 2 - 6, *Limit on Number of Waiver Individuals (Waiting List)*; and

3. Offered the choice of nursing facility or home and community-based waiver services.

B. If the eligible applicant chooses nursing facility services, the waiver case manager will provide the applicant with information and assistance necessary to access such facilities.

C. If the applicant chooses home and community-based waiver services and there is not a waiting list, the waiver case manager will notify the eligibility worker to open the case and the effective date of waiver services. The applicant will then be given the opportunity to choose the provider(s) of waiver services if more than one qualified provider is available to render the services.

D. The waiver case manager and the applicant or legal representative must document the applicant's decision by completing the Initial and Annual Level of Care/Freedom of Choice Certification Form.

2 - 6 Limit on Number of Waiver Recipients (Waiting List)

The number of recipients who may be served at any point in time through this home and community-based waiver program is limited. When the number of applicants for the waiver exceeds the number of approved openings (or "replaceable slots"), a waiting list will be established. Generally, priority for admission to the waiver from the waiting list will be given to the applicant with the highest numerical ranking based on the following:

TARGETING CONDITION(S)	WEIGHT FACTOR	
Trach/Ventilator dependent	10	
Trach dependent	8	
C-Pap / Bi-PAP	2	+ (see NOTE)
Central line	2	+ (see NOTE)

[NOTE: in considering these conditions, if the applicant is receiving skilled nursing care 3 or more times per week, add 2 points; if the applicant is receiving enteral feeding of TPN, add 1 point]
Length of time on the waiting list will be used in determining who is selected if more than one applicant has the same "highest" score.

Waiver case managers have discretion to consider extraordinary psycho-social or medical needs of an applicant/family when establishing priority for admission to the waiver. In such cases, documentation will be maintained by the case manager to include: 1) a description of the specific, extraordinary psycho-social / medical need(s) of the applicant/family member; 2) feasible alternatives (including formal and informal support systems and services) considered / available at the time to ameliorate the extraordinary need(s) and maintain the child in the community while waiting for waiver coverage; 3) an estimate of the likelihood of 'imminent' out-of-home placement (institutional or non-institutional) of the child if waiver admission is delayed; and 4) the case manager's judgment regarding the potential risks to the applicant's / care-giver's health and welfare if waiver admission is delayed.

Discretionary priority for admission will only be authorized when the case manager's documentation indicates one or more of the following: 1) the applicant / care-giver lacks any feasible / available family or community-based support; 2) the applicant is at imminent risk of out-of-home placement; or 3) there is a likelihood that the health and welfare of the applicant / care-giver will be compromised by delaying admission; and there are no others ahead of the applicant on the waiting list with equal or greater 'priority needs'.

2 - 7 Prior Authorization and Plan of Care

A. All waiver services must be prior authorized and provided pursuant to a written plan of care developed by the waiver case manager with input from the recipient and/or the recipient's legal guardian, and others as appropriate. The plan of care describes the waiver services that the individual needs, and the non-waiver services the individual is receiving. The plan of care includes the type, amount, duration, and estimated frequencies of waiver services and the provider(s) who will furnish the services.

B. The plan of care is reviewed as frequently as necessary to ensure it meets the needs of the individual. A formal review of the plan is required at least every six months and must be completed by the case manager during the calendar month in which it is due.

2 - 8 Periodic Review of the Level of Care (Re-certification)

A. The waiver case manager must periodically conduct a comprehensive reassessment to document the individual's current level of care and to assure that home and community-based waiver services remain a feasible alternative to institutionalization and continue to meet the individual's needs. The reassessment updates and documents the individual's medical history and current technology as well as psycho-social needs. Re-certification of the individual's level of care must occur at least once a year (12 months from the individual's entry into the waiver or within 12 months of the most recent level of care determination). Re-certification must be completed within the calendar month in which it is due.

B. The comprehensive assessment provides the information necessary for the waiver case manager to determine whether the recipient continues to meet the waiver targeting criteria or not. If the case manager determines that the recipient continues to meet the waiver targeting criteria and chooses to continue receiving home and community-based waiver services, the case manager will recertify the recipient's waiver level of care. If the waiver case manager determines that the recipient no longer meets the waiver targeting criteria or the recipient chooses nursing facility placement rather than home and community-based services, the recipient will not be recertified.

2 - 9 Reduction or Termination of Home and Community-Based Waiver Services

The case manager will provide written notice to the recipient or legal representative when a decision is made to terminate a recipient's waiver eligibility or when taking an adverse action resulting in an un-agreed upon reduction of home and community-based waiver services. Written notice of termination from or reduction of waiver services will include rights of appeal.

Reasons for terminating or reducing home and community-based waiver eligibility are any of the following:

1. Death of the individual;
2. Whereabouts of the individual is unknown;
3. Individual no longer meets the waiver level of care or targeting criteria;
4. Individual moved out of the State of Utah;
5. Voluntary withdrawal of the individual from the program;
6. Home and community-based waiver services are no longer a safe and feasible option;
7. Change in financial status of the individual;

8. Change in the health or functional status of the recipient or primary care-giver; or

9. Extended hospitalization or institutionalization, including a public institution.

Reductions in services which are mutually agreed to by the recipient or the recipient's legal representative and the waiver case manager will be documented in the case manager's notes and the recipient's care plan.

2 - 10 Fair Hearings

Waiver applicants and recipients will be given the opportunity for a hearing if:

A. The case manager determines the individual's needs cannot be met appropriately in the community with or without other available state plan services;

B. They are determined eligible but not offered the choice of institutional care or community-based waiver services;

C. They are denied the home and community-based waiver services of their choice; or

D. They are denied the waiver provider(s) of their choice if more than one provider is available to render the service(s).

3 SCOPE OF SERVICE

Waiver recipients are eligible to receive regular State Plan Medicaid program benefits such as private duty nursing services, pharmaceuticals, and medical equipment and supplies. In addition, when necessary to prevent institutionalization and delivered pursuant to an approved plan of care, the following "waiver services" are available:

- Respite Care
- In-Home Respiratory Care
- Family Support Services
- Nutritional Evaluation and In-Home-Based Treatment

Details concerning coverage of these services are contained in the remainder of this chapter.

3 - 1 Respite Care

A. Definition

Respite care is a service provided on behalf of an eligible individual to relieve the primary care giver from the stress of providing continuous care, thereby avoiding premature or unnecessary institutionalization. Respite care may be provided in the home or other approved community settings.

B. Qualified Providers

Qualified respite care providers include Medicaid enrolled, licensed home health agencies which:

1. Employ or contract with registered nurses, licensed practical nurses (licensed in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended) and home health aides (certified in accordance with Utah Administrative Code R432-700-22); and

2. Are capable of providing respite care services to technology dependent, medically fragile individuals in their homes and other approved community-based settings.

C. Reimbursement for Services

Respite care services must be prior authorized by the waiver case manager and be based on the needs of the individual and family. The case manager in conjunction with the family and other professionals, if necessary, will determine the appropriate level of respite provider (RN, LPN, or HHA), the location, and number of units that will be authorized.

D. Procedure Codes for Respite Care

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
RN, per 15 min	T1005	U7		58 - Home Health Agency
LPN, per 15 min	T1005	TE	U7	
Home Health Aide, per 15 min	T1005	52	U7	

3 - 2 In-Home Respiratory Care Service

A. Definition

In-home respiratory care is provided to promote optimal cardiopulmonary function and health. It is provided by licensed respiratory therapists who apply scientific principles to prevent, identify, and treat acute or chronic dysfunction of the cardiopulmonary system. Critical thinking, patient/environmental assessment skills, and evidence-based clinical practice guidelines enables respiratory therapists to develop and implement effective care plans, patient-driven protocols, disease-based clinical pathways and disease management programs. In-home respiratory care includes a comprehensive assessment, monitoring signs and symptoms, providing diagnostic and therapeutic modalities and services, disease management, patient and care-giver education, and communication with the child's medical home.

B. Qualified Providers

Qualified providers include Medicaid enrolled home health agencies which employ or contract with licensed respiratory therapists.

C. Reimbursement for Services

1. In-home respiratory care must be prescribed by a physician and consistent with applicable laws, regulations, and medical direction in accordance with Title 58, Chapter 57 of Utah's Division of Occupational and Professional Licensing Respiratory Care Practice Act.

2. In-home respiratory care must be prior authorized by the waiver case manager and will be authorized on a short-term basis to provide assessment and treatment for an acute illness. Services will be authorized on the basis of documented medical necessity when the need for respiratory care exceeds the level of service that is routinely performed by a registered nurse or a licensed practical nurse.

D. Procedure Codes

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
	G0238	U7		58 - Home Health Agency

3 - 3 Nutritional Evaluation and In-Home-Based Treatment

A. Definition

Nutritional evaluation and in-home treatment are specialized diagnostic and treatment services provided by a qualified professional to enhance the ability of an individual who cannot obtain adequate nutrition through ordinary means (oral intake of adequate food and nutritional substances).

1. Nutritional Evaluations and In-Home Treatment

   Nutritional evaluations and in-home treatment may be provided by one or more of the following providers for the purposes stated:

   a. A **certified dietician**; measures height and weight, records diet history, analyzes caloric and nutrient intake, calculates fat and muscle stores, and performs nutritional education for families.

   b. A **licensed speech therapist or occupational therapist**; collaborates with the Medical Home and other professionals to assess function and provide options and instruction on promoting oral intake; evaluates self-feeding skills and modification of equipment for self-feeding; and develops and instructs care-giver on a home feeding program.

   c. A **licensed physical therapist**; evaluates positioning necessary for safe feeding; adapts and modifies positioning equipment for feeding; evaluates oral motor problems; and develops a home feeding program.

B. Qualified Providers

Qualified providers of nutritional evaluation and in-home treatment services include:

1. Medicaid enrolled home health agencies that employ or contract with licensed physical therapists, licensed occupational therapists, licensed speech pathologists and certified dieticians.

2. The State's Maternal and Child Health agency and agencies under contract with the Maternal and Child Health agency.

C. Reimbursement for Services

1. Nutritional evaluation and in-home treatment services must be prior authorized by the waiver case manager and must be included in the plan of care. Services will be authorized on the basis of documented medical necessity.

D. Procedure Codes

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Nutritional Evaluation and In-Home Treatment per 15 minutes	G0270	U7		46 - Agency, and 58 - Home Health Agency

3 - 4 Family and Client Support Services

A. Definition

Family support services include counseling and expressive/child life services; each for the purpose of providing support to assist families in coping with the emotional, psychological, and social stressors that accompany having a child with a chronic illness. Family support services provide families, including siblings, with various methods and means to express themselves in ways that can bridge differences in age, language, abilities and cultural boundaries. Through support and coping strategies, the family is enabled to manage their stress which improves the likelihood that the recipients will continue to be cared for in the community.

1. Family counseling provides counseling and emotional support to assist with psychosocial, spiritual, and economic needs. Examples beyond supportive need include accessing community resources, decision-making, anticipatory and end-of-life planning.
2. Expressive/child life services enable the waiver recipient and sibling(s) expressive outlets for dealing with stress and emotional issues. Expressive/child life specialists use various mediums, including art, music, play, and other forms of expression that are age and developmentally appropriate to facilitate communication of thoughts and feelings related to an illness, specific procedure, or event.
3. All family support services are provided pursuant to a comprehensive assessment and treatment plan. Approved providers include a licensed MSW, LCSW, psychologist or licensed family therapist (LFT). In addition, child life/expressive services may be provided by a child life specialist under the direction of one of the licensed clinicians previously listed.

B. Qualified Providers

1. Medicare/Medicaid certified and enrolled home health agencies that employ or contract with a licensed MSW, LCSW, Psychologist, and/or LFT; and Child Life/Expressive Specialists who have a minimum of a Bachelor's degree, specialized training, and relevant work experience.
2. The Maternal and Child Health agency, and other qualified individuals or agencies only with approval of the State's Maternal and Child Health agency.

C. Reimbursement for Services

1. Services are authorized by the waiver case manager on the basis of family need. Whenever possible, the provider must contact the case manager in advance of the counseling session to obtain authorization. If the provider delivers services to a family in crisis, the provider must notify the case manager within 3 working days of the emergency to request authorization for payment of the service.
2. Family and client support services are limited to recipients and family members. Family members are defined as the persons who live with or directly provide care to the individual, and may include a parent, spouse, children, relatives, foster family, or in-laws. Family members do not include individuals who are employed to care for the individual.

D. Procedure Code

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Expressive/Child Life Services, per 15 minutes	H2032	U7		46 - Agency, and 58 - Home Health Agency
Counseling, per 15 minutes	T1027	U7		46 - Agency, and 58 - Home Health Agency

4 RECORD KEEPING

A. All home and community-based waiver service providers must develop and maintain written documentation for each billed service that indicates the following:

1. the name of the individual;
2. the specific services rendered as they relate to the plan of care;
3. the date each service was rendered;
4. the amount of time it took to deliver the service(s);
5. the setting in which the services were rendered [e.g., home, office, etc.]; and
6. the qualified individual who rendered the services.

B. The record must be kept on file and made available as requested for State or Federal auditing and assessment purposes.

5 PROCEDURE CODES (SUMMARY)

The following list of procedure codes is a summary of codes covered by Medicaid under the Home and Community-Based Waiver for Technology Dependent, Medically Fragile Individuals. All services are limited to the provider types noted for each procedure code.

PROCEDURE CODE	MOD 1	MOD 2	DESCRIPTION	PROVIDER TYPE(s)
			Respite Care, Community-Based:	58 - Home Health Agency
T1005	U7		RN, per 15 min	
T1005	TE	U7	LPN, per 15 min	
T1005	52	U7	HH Aide, per 15 min	
G0238	U7		In-Home Respiratory Therapy; per 15 min	58 - Home Health Agency
G0270	U7		Nutritional Evaluation and In-Home Treatment, per 15 min	46 - Agency, and 58 - Home Health Agency
T1027	U7		Family Support Counseling, per 15 min	46 - Agency, and 58 - Home Health Agency
H2032	U7		Family Support Expressive/Child Life Services, per 15 min	46 - Agency, and 58 - Home Health Agency